BC-VOC-100 (Rev. 4/00)

Special instruction for the PDF version:
(1) Please print this form on Legal sized (8.5" x 14") paper, if possible.

FOR BOARD OR JP USE ONLY
CLAIM NUMBER:
USER ID:

VICTIM APPLICATION FOR CRIME VICTIM COMPENSATION

(PLEASE TYPE OR PRINT CLEARLY IN INK AND USE ADDITIONAL PAPER IF NEEDED)

PERSONAL INFORMATION

VICTIM'S Name (First, Middle, Last): _____

Victim's Street Address: _____ Victim's Date of Birth: ____/____/____

City/State/Zip: _____ Victim's Social Security Number: ____/____/____

Daytime Telephone No: ( ) - _____ Victim's Gender: ☐ Male ☐ Female

If Victim is Deceased, Date of Death: ____/____/____

From the date of the crime to the present, has the victim been in prison, on probation, or on parole because of a felony? ☐ Yes ☐ No

YOUR Name (First, Middle, Last): _____

(If the victim is a minor, deceased or incapacitated)

Your Street Address: _____ Your Date of Birth: ____/____/____

City/State/Zip: _____ Your Social Security Number: ____/____/____

Daytime Telephone No: ( ) - _____ Your Gender: ☐ Male ☐ Female

Your Relationship to Victim: _____

CRIME INFORMATION

Law Enforcement, CPS or Agency the Crime was Reported to: _____

Location of Crime: _____ Date of Crime: _____/____/_____

Case/Crime Report Number: _____ Date Crime Reported: _____/____/_____

Type of Crime (Crime Code, if known): _____

Describe Injuries: _____

Person(s) who Committed the Crime (Suspect), if known (First, Middle, Last): _____

LOSS INFORMATION

Check the expenses/losses for which you are seeking compensation from the Victims of Crime Program. You must attempt to recover your losses from any/all other source(s).

- ☐ Medical/Dental Expenses for the Victim
- ☐ Mental Health Treatment or Counseling
- ☐ Wage or Income Loss
- ☐ Support Loss for Dependents of a Deceased or Disabled Victim
- ☐ Funeral and/or Burial Expenses
- ☐ Job Retraining for a Disabled Victim
- ☐ Home or Vehicle Modifications for a Disabled Victim
- ☐ Home Security Improvements
- ☐ Moving/Relocation Expenses

Each person applying for compensation from this Program must file a separate application.

Does a **family member** or other **dependent** need an Application? ☐ Yes ☐ No

If yes, how many applications should the Program mail to you? _____

Did the **victim** miss work as a result of crime related injuries? ☐ Yes ☐ No

Does the victim wish to apply for an Emergency Award (defined as an advance) for lost income, crime related medical bills, funeral and/or burial expenses or moving/relocation expenses for adult victims of domestic violence (SEE ATTACHED BROCHURE FOR REQUIRED DOCUMENTATION)? ☐ Yes ☐ No

EMPLOYER INFORMATION (Victim's employer)

_____ (Employer's Business Name) _____ (Contact Person) ( ) - _____ (Telephone Number)

_____ (Street Address) _____ (City/State/Zip)

Is/was the Victim Self-Employed? ☐ Yes ☐ No

PROVIDER INFORMATION (List Service Providers)

Name	Street Address/City/State/Zip	Telephone Number
		( ) -
		( ) -

(Use additional paper, if needed, and attach copies of bills, if available)

REIMBURSEMENT/RECOVERY INFORMATION (Check all insurance/recovery sources that may apply)

☐ Health ☐ Medi-Cal ☐ Medicare ☐ Auto ☐ Workers Compensation ☐ Homeowners/Renters ☐ None

Name of Insurance Company: _____ Policy No: _____ Telephone No: ( ) - _____

Name of Insured: _____ Social Security Number of Insured: _____/_____/_____

Have you filed a civil law suit or insurance action for this crime? ☐ Yes ☐ No ☐ Undecided

Attorney's Name: _____ Telephone No: ( ) - _____

Other Potential Sources of Reimbursement/Recovery: _____

(Use additional paper, if needed)

REPRESENTATIVE INFORMATION

Representative for this Application [Victim/Witness (V/W) Assistance Center, Attorney, or other]

Name of Representative: _____ Representative Phone No: ( ) - _____

V/W Center Name and Code No: _____ If Attorney, State Bar No: _____

Representative's Signature: _____ Date: _____

INFORMATION RELEASE (This release must be signed and dated for compensation consideration)

I give permission to any hospital, clinic, doctor, dentist, or mental health provider; any funeral director or similar person; any employer; any police or governmental agency, including the Department of Justice, the State Franchise Tax Board and the Federal Internal Revenue Service; any insurance company; or any other person or agency; to provide information relating to this application, including medical, mental health and felony conviction records to the Victims of Crime Program or its representatives. I understand the information will be used to determine compensation benefits, and that only information needed to make a decision about compensation will be requested by the Victims of Crime Program.

I understand a photocopy or FAX (facsimile) of this signed form is as valid as the original, and that my signature gives permission for the release of all information specified in this permission form.

I understand that the Victims of Crime Program or its representatives may pursue restitution from the convicted offender in this matter to recover monies paid to me or on my behalf by the Program and that by filing this application I have authorized the Program to use information contained in this application and subsequent claim files to pursue restitution from the convicted offender.

Do you want to be notified by the Program if a restitution hearing is going to be conducted by the court? ☐ Yes ☐ No

I agree that the Victims of Crime Program or its representatives may provide information about this application to any representative named on this application, governmental agency, or any medical, dental, mental health, or funeral and/or burial provider of services, and may pay the provider directly if payment of these services is approved.

I declare under penalty of perjury under the laws of the State of California (Penal Code Sections 72, 118 and 129) that I have read all the questions and the completed application and, to the best of my information and belief, all my answers are true, correct, and complete. I further understand that if I have provided any information that is false, intentionally incomplete or misleading, I may be found liable under Government Code Section 12651 for filing a false claim and/or guilty of a misdemeanor or felony, punishable by six months or more in the county jail, up to four years in state prison, and/or fined up to ten thousand dollars ($10,000).

Signed: _____ Date: _____
(Victim's signature. Parent or guardian must sign if victim is a minor, deceased or incapacitated)

MY PROMISE TO THE VICTIMS OF CRIME PROGRAM (This promise must be signed and dated for compensation consideration)

As required by California law, I will contact and repay the Victims of Crime Program if I receive any payments from the offender, a civil lawsuit, an insurance policy, or any other government or private agency to cover expenses for which I have already received payment from this Program. I understand that I may be responsible for repaying the Victims of Crime Program any amounts for which it is later determined that I was not eligible. I will notify the Victims of Crime Program if I hire an attorney to represent me in any action related to this crime or if I pursue any action on my own.

Any money I receive from the Victims of Crime Program for moving/relocation expenses, improving home security or for modifying a home or vehicle for a disabled victim will only be used for those purposes. If I am a victim of domestic violence receiving moving/relocation expenses, I will not tell the offender my home address, nor allow the offender on the premises at any time, or I will seek a restraining order against the offender.

Signed: _____ Date: _____
(Victim's signature. Parent or guardian must sign if victim is a minor, deceased or incapacitated)

HOW DID YOU FIND OUT ABOUT THE VICTIMS OF CRIME PROGRAM?

☐ Police ☐ Sheriff ☐ Highway Patrol ☐ District Attorney ☐ Medical Provider (Name): _____
☐ Victim/Witness Center ☐ Children's Protective Services ☐ Mental Health Provider (Name): _____
☐ Media (TV, Radio, Newspaper, etc.) ☐ Victim Service Programs ☐ 1-800-VICTIMS

FEDERAL REPORTING INFORMATION

The following voluntary victim information is used for statistical purposes only to comply with Federal Regulations.

Is the Victim Disabled? ☐ Yes ☐ No Was the Victim Disabled Prior to the Date of the Crime? ☐ Yes ☐ No

Ethnicity of Victim: ☐ African American ☐ Asian/Pacific Islander ☐ Caucasian ☐ Hispanic ☐ Native American
☐ Other (Specify): _____

Mail the completed application to:

VICTIMS OF CRIME PROGRAM
STATE BOARD OF CONTROL
P.O. Box 3036
Sacramento CA 95812-9915